State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

All persons who are requesting a determination as to whether a CON is required for a proposed project must complete this form. Completed forms should be submitted to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	**Collins I.V. Care, Inc.**	
Doing Business As	**Collins I.V. Care**	
Name of Parent Corporation	**Air Products Healthcare**	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	**60 Watson Boulevard Stratford, CT 06615**	
Petitioner type (e.g., P for profit and NP for Not for Profit)	**P**	
Name of Contact person, including title	**John R. Collins General Manager**	
Contact person's street mailing address	**60 Watson Boulevard Stratford, CT 06615**	
Contact person's phone, fax and e-mail address	**Phone 203 383-7777 Fax 203 383-7799 jcollins@airproductshc.com**	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title:
Ambulatory Infusion Suite (Free Standing)

b. Location of proposal (Town including street address):
60 Watson Boulevard, Stratford, CT 06615

c. List all the municipalities this project is intended to serve:
Bridgeport, Stratford, Fairfield, Trumbull, Easton, Milford

d. Estimated starting date for the project:
September 1, 2005

e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in all the boxes that apply)

E	P		E	P		E	P	
☐	☐	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
☐	☐	Behavioral Health Provider	☐	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Hospital Affiliate	☐	**X**	Other (specify):_____ **Ambulatory Infusion Suite**			

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure/Cost: **$ 101,500**

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

New Construction/Renovations	**$ 75,000**
Medical Equipment (Purchase)	0
Imaging Equipment (Purchase)	0
Non-Medical Equipment (Purchase)	**$25,000**
Sales Tax	**$1,500**
Delivery & Installation	Included
Total Capital Expenditure	**$101,500**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$101,500**

Major Medical and/or imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
N/A				
N/A				

Note: Provide copy of contract with vendor for medical equipment.

c. Type of financing or funding source:

X	Operating Funds	☐	Lease Financing	☐	Conventional Loan
☐	Charitable Contributions	☐	CHEFA Financing	☐	Grant Funding
☐	Funded Depreciation	☐	Other (specify): _____		

SECTION IV. PROPOSAL DESCRIPTION

Please see attachment 1

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Will you be charging a facility fee?
4. Who is the current population served and who is the target population to be served?
5. Who will be providing the service?
6. Who are the payers of this service?

SECTION V. AFFIDAVIT

Applicant: **Collins I.V. Care, Inc.**

Project Title: **Ambulatory Infusion Suite (Free-Standing)**

I, **John R. Collins, General Manager of Collins I.V. Care, Inc.** being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that **Collins I.V. Care** complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature J Collins Date 7/21/2005

Subscribed and sworn to before me on 7/21/2005

Cecilia B. MacDonald
Notary Public/Commissioner of Superior Court

My commission expires: 7/3/2010

AMHealth Group–
Genox Homecare and Collins I.V. Care

Main Office
AMHealth Group
and Collins I.V. Care
60 Watson Boulevard
Stratford, CT 06615

Tel 888-291-3334 AMHealth Group
Tel 800-205-5467 Collins I.V. Care
Tel 888-291-3334 Genox Homecare

Other Locations
Genox Homecare
125 Masarik Avenue
Stratford, CT 06615
Tel 203-377-5849
Tel 800-733-3613
Fax 203-386-9689

Genox Homecare
22 Shepard Drive
Newington, CT 06111-1158
Tel 860-570-1010
Tel 800-733-3613
Fax 860-570-1013

Genox Homecare
3 Mattoon Road
Waterbury, CT 06708
Tel 203-759-3650
Tel 800-733-3613
Fax 860-570-1013

Genox Homecare
82 Boston Post Road
Waterford, CT 06385
Tel 860-444-4965
Tel 800-733-3613
Fax 860-444-4969

Collins I.V. Care CON Determination Attachment 1

1. Collins I.V. Care, Inc. is a pharmacy licensed in the State of Connecticut providing Home Infusion Therapy throughout the State of CT. Our staff consists of qualified infusion pharmacists, nurses, pharmacy technicians. Care is provided to patients in their homes. Collins I.V. Care is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Please see Pharmacy License attachment 2.

2) The proposal is to establish a suite within our existing building where patients can come to receive infusions administered by qualified infusion nurses, an ambulatory infusion suite. The patients are currently being serviced in the hospital or at home.

4. The majority of the patients are receiving infusions at certain intervals (weekly, bi-weekly, monthly). The infusions typically need to be administered over an extended period of time (3-4 hours) and need to be administered under the supervision of a qualified Registered Nurse. Utilizing the ambulatory suite would be provided as an option for patients if geographically and logistically convenient for the patient.

A small minority of patients would come to the center for weekly IV line care if it would be more convenient than having a nurse come to their home.

5. Services will be provided by qualified infusion registered nurses. Supervision and direction would be provided by the Vice President of Operations who is also a registered nurse certified in infusion therapy.

3&6. Commercial Insurance would be billed for services. There will not be a "facility fee". A traditional per visit rate for pharmacy and nursing services, medications and supplies will be billed to the commercial payers, e.g. Managed Care Organizations.